State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
BOARD OF PODIATRIC MEDICINE
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The Honorable Carl Washington
California State Assembly
State Capitol Building, Room 2136
Sacramento, CA 95814

Dear Mr. Washington:

The State Board of Podiatric Medicine (BPM) has endorsed the *Model Law* developed by the national Federation of Podiatric Medical Boards (FPMB) and strongly recommends passage of your bill **AB 2728** to enact it provisions in California.

The FPMB drafted the *Model Law* following principles developed by the Pew Health Professions Commission. The Federation studied all 50 state laws and benefited from input from the various state regulators. As the immediate past president of the Federation of State Medical Boards (FSMB) recently commented, the 1998 report of the Pew Commission's Taskforce on Health Care Workforce Regulation "is on the shelf but it contains recommendations that should be implemented."

The 1998 Pew report, *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation*, recommends "using the least restrictive practice acts for each profession as models for the rest of the states, unless . . . a given act was enacted on grounds other than evidence of competence." This was based on the vision expressed in its1995 report, *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*. That recommends "a flexible, rational and cost-effective health care system that allows effective working relationships among health care providers."

Based on these principles, the Federation's *Model Law* is designed to:

1. facilitate uniformity among state licensing requirements
2. increase license portability across state lines, and
3. improve patient care by allowing licensees to utilize their full scope of training & competence

As some *Model Law* provisions will be considered by the Joint Legislative Sunset Review Committee, this letter will focus on modernizing the scope of practice. Like other doctors, DPMs are restricted by their competence and training through peer review and privileging in health care facilities. Unlike other doctors, they are also restricted by the state license itself to their general area of specialty training. The Model Law would retain this distinction, but update California law to reflect many education and training changes over past decades.

The current language of Section 2472 of the Medical Practice Act dates from 1921. It was written to restrict chiropody, the forerunner to podiatric medicine as we have known it now since the middle of the last century. DPMs often find themselves hamstrung from performing routine procedures that patients and medical staffs want them to perform. Current law sometimes forces procedures to be performed by persons with less medical training.

The Podiatric Scope

The *Model Law* provides a better description of what DPMs are trained to do while eliminating practical problems commonly confronting them because of how they are licensed.

Regulation of podiatric medical specialists presents unique problems. MDs, because of their non-specialty-restricted license, are licensed to perform many procedures in which they are not competent. They are fully licensed for every medical specialty in addition to their own. This indeed is sometimes the basis for physician discipline. DPMs, on the other hand, are restricted by the state license itself from performing many procedures in which they are thoroughly trained. Few physicians would advocate specialty licensing. The *Model Law* attempts to make it work better for DPMs.

The 1996 UCSF Center for the Health Profession report, *Podiatry's Role in Primary Care*, commented: "Clearly, their broad medical background can and does assist them in providing care to the foot and leg, as well as identifying other biomedical and behavioral problems their patients may have."

It is difficult and frustrating for everyone, for example, for DPMs to explain to patients and medical staffs that they can treat a complicated wound on the foot, but must refer that same patient to another doctor for treatment of a minor wound or less serious skin condition an inch above the ankle.

Is a complex fracture of the ankle joint involving damage to the tibia or fibula (inserting into and part of it) an ankle fracture or a leg fracture? Since the early 1980s, the Board has indicated it considers that to be within the scope of ankle surgery, and that professional judgement and common sense distinguish between an ankle fracture and a leg fracture ("you know it when you see it"). But the question naturally arises continually in hospitals throughout California.

These are typical of the questions confronting DPMs every day. The Model Law would put them to rest in a clear, common-sense manner.

Surgical Assisting

Patients and other surgeons frequently wish DPMs to assist in non-podiatric procedures because of their surgical skill and trusted doctor-patient relationships. It makes little sense to use a non-licensed technician rather than a DPM to assist in surgery. When podiatrists are credentialed by hospitals to perform complex procedures of the foot and ankle as the *primary* surgeon, there is no logical reason why they should not be permitted to function under their license to *assist* an orthopedic surgeon on procedures involving the knee, hip, or upper extremity.

Many physicians agree, and utilize DPMs as they consider appropriate together with nurses, physician assistants, and surgical technicians. Under California law, this is legal, and the physicians, physician assistants, nurses and unlicensed technicians may all be paid for their services. The DPMs, however, because they are working as unlicensed technicians outside of their scope, are most often not.

Many DPMs grasp these opportunities nevertheless to foster cross-specialty collaboration, sharing of expertise, and enhanced patient care. But it seems wrong that under State law they are the only ones in the operating room who cannot be paid.

The *Model Law* is designed to utilize the DPM's full training for the benefit of the patient--both in the DPM's own independent practice of podiatric medicine, and in MD-supervised assistance in non-podiatric procedures. Under the *Model Law* provisions in AB 2728, DPMs could assist MDs ***only*** when the MD desired and ***always*** under the MD's supervision.

Elaine S. Davis, DPM, a BPM Board Member and Past President, and herself a partner in a multi-specialty medical practice, commented:

> I just wanted to give my perspective re: the importance of podiatrists being able to assist MD's in surgery and practice outside podiatry under supervision of an MD. In particular, it is extremely important that podiatric surgeons be allowed to assist MD's in surgery so that they do not become isolated in their specialty and continue receiving first-hand exposure to advances in general surgery and orthopaedics. This type of ongoing experience definitely improves the skills and expands the base of knowledge for podiatrists to use in the normal scope of their practice.

The Pew Health Professions Commission recommended: “Require interdisciplinary competence in all health professionals. . . . To assure effective and efficient coordination of care, health professionals must work interdependently in carrying out their roles and responsibilities, conveying mutual respect, trust, support and appreciation of each discipline’s unique contributions to health care.” [*Recreating Health Professional Practice for a New Century*, 1998]

The benefits to California will not be one-sided towards podiatric medicine. In the 1993 *Report on the General Medical and Surgical Components of Podiatric Residency Training in California: A Report to the Medical Board of California and the Board of Podiatric Medicine in California*], Franklin J. Medio, PhD and Thomas L. Nelson, MD reported:

> In the teaching hospital, . . . many faculty commented on the teaching contributions made by podiatric residents, both formally and informally. Frequently these are contributions to them and the medical residents and students about topics in podiatry. . . . Repeatedly we heard statements such as . . . "they teach us things we need to know."

"No Podiatrist shall . . . "

While discriminatory language such as "No podiatrist shall" was perhaps not uncommon in the 1920s and 1930s, here and abroad, BPM submits that this does not belong in 21st Century California law. The State Board of Podiatric Medicine respectfully requests that it be rescinded as wholly unnecessary, unjustified, and inappropriate.

"No podiatrist shall do any amputation."

Since at least 1983, the Board of Podiatric Medicine (BPM) has interpreted §2472's use of the term "amputation" to mean amputation of the foot in toto. In many health facilities, and within the American Diabetes Association, DPMs are recognized as experts in diabetic foot care. DPMs specialize in saving feet and in the removal of necrotic tissue, i.e., amputations short of the entire foot, when necessary in order to save the limb. "Amputation" has a strong emotional impact, but is not among the most complex procedures surgeons perform. It is one many medical staffs prefer to delegate to the podiatric surgeon. The law is obsolete and unnecessary. Its literal interpretation would disrupt diabetic foot care in California.

"No podiatrist shall . . . administer an anesthetic other than local."

In the health facility setting, DPMs are privileged based on documented training and competence, together with MDs, in peer review systems controlled by MDs. Only anesthesiologists and nurse-anesthetists are privileged by hospitals to administer a general anesthetic. Anesthesiologists and pain management specialists must be given special privileges to perform epidural and spinal blocks as well. Surgeons, in general, and podiatrists, in particular, would never be privileged to do more than provide some sedation to their patients during a procedure, usually as an adjunct to the use of local anesthetics. When such sedation is given, there are strict protocols as to the monitoring required of such patients. Narrow and strict interpretation of existing law would prevent a podiatrist from prescribing appropriate sedatives to a patient during a procedure as needed to relieve anxiety or pain. BPM has ample authority to deal with unprofessional conduct under Section 2234.

The Board of Podiatric Medicine endorses and wishes you every success with AB 2728. The time for enactment of its important provisions is overdue.

Sincerely,

Jim Rathlesberger, M.P.A.
Executive Officer
Board of Podiatric Medicine